Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 1/26/12
Amount 1730.00

NF-1650.00
PC. 80.00

#19322

I. IDENTIFICATION

Name: Woodland Oaks Health Care Facility

Address: 1820 Oakview Road

City/County/Zip: Ashland / Boyd / 41102

Telephone number: 606-325-5200

Administrator: Kim Nall

Date facility operation began at current address: January 1994

Date facility began operation under current owner: January 1994

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	110	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	**Profit X**	Individual
County	Nonprofit	Partnership
City		**Corporation XX**
Private X		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Woodland Oaks Manor, LLC
300 Provider Court, Suite 100
Richmond, KY 40475

RECEIVED
JAN 26 2012
OFFICE OF INSPECTOR GENERAL

1/31

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Woodland Oaks Manor, LLC

Address of corporation 300 Provider Court, Suite 100, Richmond, KY 40475

Member Delbert Ousley

Member John D. Sword

Member Estate of Fred Nall

Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
	PMD Corporation
	300 Provider Court, Suite 100
	Richmond, KY 40475

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
	V.P. Finance	1/12/12

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)